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ABSTRACT

A World Health Organization (WHO) working group discussed continuing education and career development of health care personnel at a meeting in Budapest, October 31-November 2, 1978. Group members defined continuing education, analyzed its methods and organization in various countries, and explored the relationship of continuing education to career development. They also identified various incentives for participation in continuing education--self-motivation, professional contact, and financial reward; and disincentives--loss of earnings, inconvenience of attending and career anxiety; and considered possible sanctions that could be applied against nonparticipants. Specific recommendations included the following: (1) continuing education should be controlled by appropriate bodies; (2) it is needed by all medical practitioners and other health professionals and should not be seen merely as a means to promotion or greater prestige; (3) it should be an integral part of employment; (4) both undergraduate and postgraduate training should take place in the widest possible range of hospitals, clinics, and practices, and (5) an adequate porportion of the health budget should be set aside for continuing education. (KC)

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Continuing Education of Health Personnel as a Factor in Career Development

Report on a WHO Working Group

Budapest
31 October – 2 November 1978

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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WHO WORKING GROUP ON CONTINUINC EDUCATION OF HEALTH PERSONNEL AS A FACTOR IN CAREER DEVELOPMENT

Budapest, 31 October – 2 November 1978

1. INTRODUCTION

On the general question of continuing education – definition, methods, aims and specific applications – a great deal has been written. It is no longer of great intrinsic interest to know that a country, a professional association or a specialty is concerned about the problem, and detailed accounts of individual programmes become wearisome. It seems sometimes that various groups are anxious, most of all, to out-do each other in the comprehensiveness of their coverage and the elaborateness of their administrative provision for continuing education, so that one wonders *why*, in the words of the Bible, "do the nations so fiercely strive ...?" Is it a sufficient end in itself to be seen to be active in this field? Surely not. Is it simply that visible activity within the profession gives protection against the imposition of demands from outside? Is there not a danger of too much "educational" activity being offered, sometimes of doubtful quality and at least as much for the benefit of the provider as the recipient? So, what of evaluation? How can we measure or infer the worth of this great movement that has grown in the last 15 years, and continues to grow? We have the same problem here as with the assessment of any fundamental change in life-style, such as a new diet or a regime of exercise: the separation of specific effects from general wellbeing and the advantages of increased self-awareness. Continuing education is, in its professional aspect, no less fundamental a style of life.

The Budapest meeting was an attempt to move beyond the purely descriptive stage of defining continuing education and noting the existence of programmes. Its purpose was to discuss the ways in which continuing education is, or might be, related to the career of an individual. This may be looked at in two ways: firstly, the requirements in terms of money, time and facilities if continuing education is to be accessible to all; secondly, the methods available, if it be accepted that continuing education is advantageous or even necessary, to ensure that all participate. The term "career development", in relation to continuing education, was chosen so as to permit the widest possible discussion of these matters. It was not taken to imply promotion or professional advancement, although it is well recognized that these rarely, if ever, occur in the absence of an active, personal belief in the importance of self-education through life. Thus the Working Group set out to consider, in the broadest terms, the place of continuing education in the context

of a health professional's career as a whole. There are many viewpoints from which this relationship can be regarded – those of the individuals concerned, of the relevant professional and academic organizations, of the producers of journals, books, films, pharmaceutical products and equipment, of trade unions, governments, and of the public who look to the health professions for competent advice, treatment and care.

The Budapest meeting was the natural and promised sequel to the meeting of the WHO Working Group on Continuing Education of Health Personnel in October 1976 in Dublin.[a] The participants included a broad representation of health professions, namely medicine, nursing, midwifery, physiotheraphy, medical laboratory technology and sociology. A list of participants is annexed to this report.

In the background paper[b] it was pointed out that no educational system, however perfect, can guarantee the continued competence of its graduates. Reassessment and retraining become necessary because of the rate at which specific skills and knowledge become obsolete, because of changes in social patterns and in the delivery of health care. Medical education must, in fact, be seen as a continuum extending throughout the duration of professional life. In regard to planning, there should, ideally, be identifiable standards for health care and practice, on the basis of which an assessment, or audit, of the actual quality of care can be made. From this it is possible to identify deficiencies in knowledge, skill or attitude and thus to designate educational priorities. After an appropriate process of learning, a further audit may be made, leading in turn to reconsideration of criteria of care and standards of practice. Up to now, continuing education has rarely been planned in this way, and there is a paucity of studies on its effectiveness.

Concerning constraints and limitations, there may be resistance from teachers, teaching institutions, medical practitioners and other health professionals. The various possible motives for participation in continuing education are discussed in the body of this report. The examples given below, of ways of encouraging participation in continuing education (CE) in the United States, are extracts from the conference background paper. Although not at present directly applicable to the European Region, they are highly interesting since they illustrate several possible attitudes and approaches.

"In the USA in 1970, the Oregon Medical Association established basic CE requirements for its members; and in 1971 it suspended 11 members who had failed to meet the requirements. When this became known publicly, the Association did not reveal the names of the suspended members, but suggested that patients ask their physician if he was a member of the Association,

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[a] **WHO Regional Office for Europe.** *Continuing education of health personnel. Report on a Working Group.* Copenhagen, 1976 (ICP/HMD 029).

[b] **Simpson, M.A.** *Continuing education in the health sciences.* WHO Regional Office for Europe, unpublished document ICP/MPM 001/6.

and if he had a certificate showing he had met the CE requirements. Membership of the Association increased and the certificate became sought after ...

"In the USA certification by a specialty board is the mechanism for giving recognition and status to new groups of self-proclaimed specialists .... Their guidelines suggest that such recertification can be based on evaluated participation in continuing education, oral or written cognitive examinations, skills and performance evaluations, practice audits and practice profiles.... Further, in 1968, the American Medical Association established a Physician's Recognition Award for physicians able to document their annual participation in 150 hours of accredited CE. By 1975 over 50 000 such awards had been made. In the 1970s large-scale self-assessment examination programmes have been set up by the major specialty societies, including identification of areas of current interest and importance in the specialty and help to physicians in recognizing their areas of weakness, to guide them in planning their CE.

"Several state medical boards, which are responsible in the USA for issuing licenses to practise, have begun to require relicensure at specified intervals, depending on a prescribed amount of time spent in accredited postgraduate educational programmes; and over a dozen state medical societies (associations of physicians) require similar CE participation to maintain membership.

"In other health professions similar requirements are developing. In nursing for example, many states give credit for voluntary participation in CE and have mechanisms for review and approval of courses.

"The American Nursing Association has established a National Accreditation Board for Continuing Education, with five regional accrediting committees. The Association's Commission on Nursing Education makes overall recommendations on the general direction of programmes, in the light of changing health care needs, practice and policy while the committees carry out site visits and review applications for accreditation of courses. In Canada standards of nursing practice have been established in the province of Ontario and the College of Nurses issues certificates of competence rather than licenses to practise. In Finland CE is mandatory for nurse-midwives by government decree.

"The American Academy of Physicians' Assistants has instituted mandatory CE. To maintain active membership, current members must complete 90 hours of CE before the anniversary date of their enrolment; for senior membership 150 hours are required over three years. The National Commission on Certification of Physicians' Assistants requires all certified assistants to engage in 100 hours of CE every two years, for their certification to remain valid. There are also plans to develop recertification examinations, starting in 1981, for those in practice for the preceding six years.

"The introduction of licensure is sometimes eagerly accepted by new health professional groups as part of defining, extending and establishing their role. CE requirements and relicensure are also beginning to be sought after by groups of health workers, both to maintain good standards of clinical practice and to improve status and prestige."

To conclude this introduction, brief comments will be made on definition, methods, organization, evaluation and attitudes, without attempting to repeat the coverage of previous reports on continuing education, including that of the Dublin meeting.

1.1 Definition

For purposes of definition, continuing education can be regarded as any education which follows completion of the formal training required for independent practice as a professional, specialized or otherwise. Although it is customary to distinguish continuing education from further specialist education which leads to the obtaining of a diploma, it would be unduly restrictive to think only in terms of revision, rather than the acquisition of new skills and knowledge. Only the most tenuous distinction can be made between continuing education and advanced further training; if a practising radiologist wishes to learn about computerized tomography, an obstetrician about fetal monitoring, or a paediatrician about genetic counselling, this is, surely, in part continuing education and in part further training in what may eventually become a new specialty. This point is important in relation to the theme of the Budapest meeting, because although continuing education may be seen as a route to professional advancement, and sometimes quite legitimately so, it is nevertheless needed by all, including the great majority whose aim is to remain competent in the same job. The working party stressed the importance of this fact.

1.2 Methods

In considering its relevance to career patterns and progression, it is essential to appreciate the wide range of ways in which continuing education may take place.

The most obvious and important method is that of reading. The range of medical journals, textbooks, abstracts, reviews and other reading matter relating to medicine is unequalled in any other field. Although there has been a recent tendency to explore alternative media, the great advantages of the printed word should not be forgotten.

Smaller books and journals are readily portable; they can be perused at will, and at whatever pace the reader desires; it is easy to refer back to previous sections or chapters, and to re-read difficult passages. No special equipment

is required; frequent new editions become available and, in comparison to other educational tools, the costs are still remarkably low. The medium is unrivalled as a means of providing standardized references to other work, and for the production of data in graphic or tabular form.

Recently there have been important trends in book and journal production: the wider use of paper-back monographs, the free dissemination of conversational-type journals which carry serious educational material along with advertising and other matter and, perhaps more importantly, the development of self-education programmes in printed form, through which the practitioner can send in his "answers" or opinions, and receive appropriate comments in return. Sectional publications, which may be read in instalments and built up into a comprehensive text, are also available.

To all this should be added pharmaceutical literature which, in some countries, is distributed to medical practitioners and other health professionals in large amounts. The importance of education in developing a critical approach to this information cannot be overemphasized. From the scientific point of view it often has limitations, but as a means of keeping practitioners informed about recent developments and available formulations it has considerable value. Closer cooperation and better understanding between the pharmaceutical industry and the health professions are important for the future, and would have great educational benefits.

Other methods of continuing education available to the health professional, for private use in his own home, include audio-tapes and slides, and specially prepared television programmes. In some countries, valuable collections of audio-tapes and slides are now available, dealing with a wide range of subjects in both clinical medicine and the basic sciences. Personal contact with visitors to the home or practice usually takes the form of discussions with representatives of pharmaceutical firms. Here again, a critical approach and a relationship based upon mutual respect are essential. The role of students, both undergraduate and postgraduate, in bringing teaching and learning beyond the confines of the traditional teaching institution and into the field of every-day practice, will be discussed later in this report.

Professional meetings take many forms, from local journal clubs and societies where films may be shown and discussions take place, to travelling clubs, and national and international conferences. Each type of meeting may have a specific purpose, or a variety of purposes; the benefits obtained may not be precisely those that were originally looked for. Similarly, continuing education courses may take many forms: short, intensive courses of one or two days, longer full-time courses extending over several weeks or months, evening courses or day-release courses which may extend over a period of months or be a routine feature of employment throughout the year. Each different type of course will have advantages and disadvantages, and its appropriateness will depend upon the circumstances. The low cost and ready accessibility of small, locally organized activities and day-release programmes must be weighed

against the social advantages, in terms of wide contact with professional colleagues, and the higher level of expertise available at large, national meetings. Again, although there are clear advantages in being able to participate in some form of continuing education while carrying on with the daily round of duties, there are also positive advantages in getting away from the job for a while in order to draw breath and look at the situation in a calmer perspective. There are both manpower and financial aspects to this which must be honestly recognized if continuing education is to achieve its full potential.

1.3 Organization

It is also important to the theme of the Budapest meeting to bear in mind the ways in which continuing education may be organized, or the sources from which the motivation may arise for the preparation of programmes and educational material.

A fundamental factor is the importance of self-motivation, and an inherent desire should be present in all health professionals to keep themselves up to date and maintain their competence. This inherent drive may be reinforced by considerations such as the possibility of financial advantage, professional promotion or increased job satisfaction, or by anxiety about the consequences of falling behind. These matters are discussed later in more detail but there will, and must, always be a demand for educational material suitable for home consumption on a personal basis.

The hospital or the local practitioners may organize programmes of continuing education, often profitably working together on them. Similarly, the local university may be the originator of continuing educational activity, and very fruitful collaboration can occur between academic university departments and local practitioners, specialists and health professionals. On a more general front, university departments may produce educational material suitable for wider consumption; in the United Kingdom the Open University is currently interested in producing postgraduate medical education programmes.

Professional organizations, such as the national associations, societies or royal colleges responsible for the individual specialties, will often arrange educational activities of great value, in the form of conferences, courses and sometimes individual clinical attachments for people wishing to learn specialized techniques or obtain practical training in a particular field, for example, obstetrical experience for general practitioners. National educational bodies may also serve a valuable purpose in assessing the educational standard of courses offered by individual specialist bodies; in the United Kingdom, for example, continuing education courses suitable for consultants are assessed by the Council for Postgraduate Medical Education for approval under the Advanced Postgraduate Training Scheme. Such approval provides some assurance of quality, and enables participants to claim study leave and expenses for their attendance.

Trade unions may bring pressure to bear in the setting up of continuing education programmes, and the provision of working conditions which enable their members to attend. This has happened in some countries, particularly in professions such as physiotherapy and medical laboratory technology. For many technicians, the right to attend some form of educational programme one day a week is recognized as an integral feature of employment, and appropriate pressures may ensure that similar arrangements are made in the employment of graduate professionals.

Government may be the prime mover in regard to continuing education, either on a statutory basis, as in the eastern European socialist countries, or on a more permissive basis whereby adequate funds and other resources are made available, and terms and conditions of service for doctors and other health professions are so arranged as to permit attendance, and even reward it.

Independent, nongovernmental bodies may also have an important part to play. An interesting example occurred in the case of continuing education for general practitioners in the United Kingdom. Following the Christchurch conference[a] the Nuffield Provincial Hospitals Trust made funds available for general practitioners who attended suitably organized continuing education meetings; once the scheme had been launched and proved its worth, the financial commitment was taken over by the Department of Health and Social Security and became an integral part of the payment of general practitioners. The additional remuneration (the postgraduate training allowance and the seniority award) would only be paid to those doctors who showed evidence of having attended a certain number of approved continuing education activities each year. During the 1960s and early 1970s many non-teaching hospitals throughout the country raised funds in various ways, including voluntary support from the local population, to set up postgraduate medical centres. These were units adjacent to the local hospitals, incorporating a library, seminar and lecture rooms and other facilities, where meetings could be held and general practitioners make contact with the local hospital specialists. Again, once the value of this initiative became apparent, the Department of Health and Social Security assumed increasing responsibility for funding such centres, which now exist in almost every town and city. This development has transformed the pattern of continuing education and medical practice in the United Kingdom, and its importance cannot be exaggerated.

The role of the pharmaceutical companies in organizing and financing continuing educational activities, including the making of films and the sponsoring of conferences, must again be mentioned. Because of its financial and social associations it has a special relevance in regard to motivation and career development. For commercial reasons, the pharmaceutical companies

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[a] **Nuffield Provincial Hospitals Trust.** Conference on postgraduate medical education. *British medical journal*, 1: 466–467 (1962).

have found it advantageous to cover all the expenses of participants and to provide generous hospitality. There is a point beyond which such flagrant inducements become suspect, but it is a fact that attendance at such meetings is high and that interest among doctors in pharmaceuticals is probably higher than in any other aspect of medical practice. There are certain lessons to be learnt from this, notably that continuing education is not likely to be successful unless adequately funded.

1.4 Evaluation

The problems of evaluation of continuing education present long-standing difficulties. The working paper referred to attempts that have been made to determine differences in patterns of practice or quality of care as a result of participation in continuing education programmes. In most cases no correlation has been demonstrable. In one study, however, where assessment was more rigorously carried out, improvement was shown in the appropriate use of antibiotics, in selection of cases for appendectomy, and reduction in the complication rate for hysterectomy.

The working paper used this as an illustration of the difference in effect between a specifically designed programme based on predetermined criteria of good practice, and the more prevalent type of "haphazard" continuing education activity.

The problem of evaluation was a recurrent theme at the Budapest meeting. On the one hand it was argued that until demonstrably effective methods of evaluation were available no further progress could be made, and the most that could be looked forward to was a vast wastage of expenditure on indiscriminate continuing educational activity. On the other hand, it was strongly urged that *complete* evaluation, in anything approaching a scientific sense, was an unattainable ideal: although some specific goals may be set, and achievement may perhaps be measured in relation to these, there will always be more general reasons for engaging in continuing education, and broader benefits which cannot be defined with any degree of precision.

The necessity for continuing education to be relevant to health needs was strongly emphasized, and the point was made that in many cases continuing education may benefit the medical practitioner or the health professional rather than the community. This is a valid point, insofar as direct professional advancement is concerned; there is clearly little place for so-called continuing education which is merely designed to enable doctors and others to obtain personal preferment. But in the more general sense, it is doubtful whether a real distinction can be made between that which directly benefits the health care of the community and that which benefits the providers of this health care. What is most needed is the development of proper attitudes towards the *use* of the knowledge and skills that are acquired or reinforced.

The distinction between specific and general aims, and effects, is an important one. The mere fact of participating in continuing education, and

indeed of reading a journal, removes the sense of isolation and brings some benefit in itself. Attendance at a meeting will provide opportunities for conversation with colleagues and escape from preoccupation with day-to-day work. Here there is an analogy with evaluation in relation to the undergraduate curriculum. It is relatively easy to devise tests of a specific course, for example the physiology of the nervous system or the biochemistry of proteins, which will provide some indication of how much the student has benefited from the teaching. When all the individual elements of the curriculum are put together, however, it is much harder to form an opinion of how much each part contributes to the production of a good doctor. There is very little knowledge of how much should still be known about the physiology of the nervous system, or the biochemistry of proteins, at the time of graduation, or ten years afterwards, and how much of the real benefit of these courses was specific, rather than general. For similar reasons it should be recognized that detailed, or specific "evaluation", as usually called for in relation to continuing education, must inevitably constitute only a partial assessment of the overall effect.

1.5 Attitudes to learning and teaching

The attitudes of medical practitioners and other health professionals to continuing education will vary with personality and background training, and according to the varieties of continuing education that are offered. This is an inevitable, and indeed welcome, fact of life. As at other stages of education, no single method or style of presentation will have universal appeal, or achieve the maximum impact on all individuals. There is no single motive from outside that can be relied on to attract all potential participants.

Comment has often been made that in a non-compulsory situation, continuing education is no more than a process of "preaching to the converted": providing courses or programmes for those enthusiasts who would probably manage very well without them, while the chronic non-attenders remain unaffected by the great wealth of activity that might help them so much. There is obvious truth in this observation, but to read too much into it implies three assumptions that can be challenged. Firstly, that attendance necessarily confers a specific benefit; secondly, that non-attendance means lack of interest, and not disillusionment with what is offered; and thirdly, that those who do not attend are not in receipt of any form of continuing education. The last assumption is obviously untenable, and it has already been noted that with the profusion of literature and adveritising material that is available, *some* form of continuing education is almost inescapable. One of the problems in evaluation of continuing education programmes is the difficulty in comparing what happens with and without, or before and after, the programme on the seemingly necessary, but dubious, assumption that the programme alone, and no other concurrent level of individual activity, is responsible for the change.

Attitudes vary not only from person to person, but with time and circumstance. It is reported (Newman, 1966)[a] that when the West London Hospital pioneered continuing education through its Postgraduate College at the end of the 19th century, there was great resentment from some leading figures of the teaching hospitals, and other practitioners, at the implication that one qualified doctor could presume to teach another. Elements of this attitude still remain in some situations, where the omnipotence of the local practitioner is a powerful factor in professional success; but the pretence is doomed as surely as it is based on deception of all but the doctor himself. The concept of the all-knowing graduate who, once he had left the medical school, needed no further contact with teaching or learning, was an uncomfortable delusion rather than a genuine belief, to some extent necessitated by the closed nature of traditional medical education. What was learnt from journals, colleagues or mistakes was never admitted and, often, still is not. Attitudes change most, and quickest, where contact is made with colleagues and students; the tendencies towards group practice and dispersion of both undergraduate and postgraduate trainees far beyond the walls of the university hospital are therefore of fundamental importance to continuing education.

Much organized continuing education is a reciprocal relationship between individuals. If the teacher is willing to give, and the student keen to learn, there should be no problem in communication. From this point of view it can be argued that course participants should be selected rather than compelled to attend. But there still remains the problem of trying to encompass too much, of achieving less than the optimum benefit through overloading of courses with information, and offering an overall surfeit of educational material. Capacity for learning is limited, however great the enthusiasm.

Coupled with this problem is the danger of "over-education" which, again, arises in relation to the needs of the community rather than the career ambitions of the individual. All professional and technical groups nowadays seek higher status and better rewards in terms of payment and position in society. An obvious means of achieving this is through longer and more demanding processes of training, greater specialization and lifelong continuing education. Increased personal satisfaction can be expected if this intellectual advancement finds fulfilment in more interesting, challenging and responsible work, but not otherwise. In many respects the forward march of science and technology requires this increased level of training and competence, and it can also reasonably be said that no member of an enlightened society should be denied the chance of an advancement which lifts him from the drudgery of an utterly mundane task. At the same time there remain humble and tedious tasks to be done, and their importance to society must be recognized frankly.

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[a] Newman, C. The history of postgraduate medical education at the West London Hospital. *Medical history*, 10: 339–359 (1966).

Perhaps the answer lies, not in a hierarchical system where each more highly trained person expects to be able to delegate all his unskilled work to an orderly, or even a well-behaved and expensive machine, but in a wider range of tasks, at different levels of stress and skill, for each individual. Here lies the ultimate educational challenge, of reconciling the needs of society with its expectations.

The building up, over centuries, of a great civilization depends on the handing on of knowledge, skill, and the wisdom born of hard experience, from one generation to the next. Inherent in man's nature is the desire to learn, whether it be the humblest art of the carpenter or the rarest technique of a Beethoven or a Velasquez, and so is the urge to improve, to test what may yet be possible. The motives may be many and complex, but they stem from an instinct, and it would be as hard to stop intelligent man from wanting to learn, as to stop the flow of the tide or the mating of birds. We may help, or hinder, or be neutral towards this constant learning activity, or so we may think. Secrets have been jealously guarded in the past, and no doubt s... are, in science just as in business and the arts. Indifference to potential learners would be more damaging, in its absence of provocation, if it did not often denote the lack of anything much worth passing on.

For most people, and perhaps especially in medicine, there is a positive desire to inform, and a dread that something of value may not be communicated, may die with the mind or the hands of its progenitor and be lost, at least temporarily, to the currency of thought and progress. Again, it is inherent in the nature of man that these concerns should not only be with the great ideas and the unique abilities of the masters, but also with the simplest of things that can be better for being understood, and done well. Much of the thrill and satisfaction of teaching arises out of this instinct. It tends to colour the practice of medicine as surely as it colours the relations of parents to their children. What is vital is the sense that what has been learnt and built up over the generations, and over the lifetime of the individual, is something that matters, and must pass on through as many channels as can be found. This awareness of the essential heritage of culture, and the purpose of the individual as a medium through which some of it must pass and perhaps be further refined but never allowed to stop, characterizes civilization. It would be presumptuous and absurd to say that this feeling of participation in a great system of intellectual construction should be instilled in the medical student as preparation for a lifetime of teaching and learning; the feeling is there, and it needs to be encouraged rather than smothered.

2. RELATIONSHIP OF CONTINUING EDUCATION TO CAREER DEVELOPMENT

2.1 Preparation for a lifetime of learning

If a practising graduate in medicine or the other health sciences has to be encouraged to continue learning, or shown how to do so, he is unsuitable for his role and should not have graduated in the first place. To begin with continuing education at the postgraduate stage is already too late.

The point has been made that the purpose of the undergraduate medical school is not to *instil* a spirit of enquiry or desire for knowledge, since these qualities are inherent in any individual intelligent enough to gain admission to higher education. Depending upon the systems and traditions of the country, it is a regrettable fact that much natural inquisitiveness and independence of thought may already have been destroyed during the process of primary or secondary education so that the student, even at the outset of the medical course, may be more predisposed to conform and learn by rote than to think for himself and criticize the pronouncements of his masters. Thus, one of the fundamental purposes of undergraduate medical education is to re-establish the right attitudes, not in conventionally respectful terms, but in preparation for independent practice and constant self-renewal. In this respect, the medical school must strive to bring out the best in its students, at whatever cost in terms of discomfort to the more orthodox teacher, and potential disruption of the blandly complacent course of events to which many schools have become accustomed.

As examples of new trends that are developing, the Working Group referred to the pattern of community-based medical education in Pécs, Hungary, where the primary objective of the curriculum is to instil a spirit of enquiry and develop facility in problem-solving. Students select their own study themes, the pursuit of which involves literature searching and original work. Thus the right kind of motivation for continuing education is encouraged and developed at the undergraduate stage. Similarly, in six new medical schools in Turkey, the emphasis is on self-learning through personal research, criticism and literature evaluation. There are no departments within the medical school, in the usual sense, and no final examination; one third of the undergraduate course is undertaken in rural areas, and the schools provide undergraduate training in medicine, dentistry, physiotherapy, nursing and dietetics. There is also a postgraduate faculty of health sciences. Many similar examples could be given, and the need to produce doctors and other health professionals who are already accustomed to seeking information for themselves and questioning the statements made to them is everywhere apparent.

Following upon this type of career preparation, to which the Working Group attached the greatest possible importance, there are various possibilities

for the association between continuing education and career development. From this point of view, the European countries can be broadly divided into two groups: those eastern European socialist countries with fully integrated systems in which continuing education is an inherent part of the state-controlled practice of medicine and the other health professions, and the remaining countries which provide a range of alternative systems in which continuing education, although not compulsory, is provided in a number of different ways.

3. ORGANIZATIONAL SYSTEMS FOR CONTINUING EDUCATION

3.1 Fully integrated systems

In the eastern European socialist countries, medicine and the allied professions are entirely controlled by the state, so that it is possible to make built-in provision for continuing education. Postgraduate education, including specialist training and continuing education, is under the general direction of a central postgraduate institute, which provides many courses and other forms of instruction, and is responsible for overall policy and administrative control throughout the country. Organizations and individuals at regional and local level are ultimately accountable to the postgraduate institute.

All practitioners, of whatever level of seniority, are expected to participate in continuing education programmes of appropriate type, and are accountable to their peers for maintaining their competence and suitability for the positions they hold. Continuing education takes many forms, from self-instruction to formal courses, and suitable plans for each individual's reinforcement of knowledge, or development of requisite new skills, are drawn up by discussion with the head of the department. The head of the department, at the same time, has available to him opinions from students and others, which enable him to supplement his assessment of the individual doctor's teaching abilities or weaknesses.

All members of the profession, including heads of departments themselves, are accountable to other members of the hierarchy, and all appointments are subject to review at four- or five-year intervals. Thus, a doctor who has not made an unqualified success of the position he occupies, who has failed to respond to suggestions as to how he might improve his teaching or practice, or who has not participated in continuing educational activities that would be regarded as appropriate, might be offered an alternative position, of less responsibility or requiring different aptitude. Such relocation, however,

would not imply a change of personal title; a professor, for example, would retain the title of professor throughout his career, although not necessarily remaining head of a department.

In general practice, there are supervisors, each of whom is responsible for overseeing the work of about 10 general practitioners. All patients who are sufficiently ill to be off work for more than one week are reviewed by the supervisor, who may discuss the case with the general practitioner and suggest alternative forms of patient care. This system of control may also help the supervisor to suggest which continuing education courses would be most appropriate for each practitioner. If a difference of opinion arises between the general practitioner and the supervisor, the question may be referred to the chief physician of the district. These supervisory arrangements apply equally to city and rural practice, and provide a link between continuing education and career progression which is based on the direct observation and control of patient care. In effect, a similar system applies, through a hierarchy of appointments, in the hospital specialties, and a comparable system exists in the nursing profession.

In many countries, for example Hungary, a shortage of nurses creates difficulties in providing release for participation in continuing education, while still maintaining an adequate work force. But in principle, each hospital has in-service training programmes for nurses, and each nurse attends a one-month course every four to five years. Such continuing education is compulsory, and nurses, like doctors, have personal cards which provide a cumulative record of courses attended

The Working Group heard a detailed account of how these arrangements operate in Hungary. Similar systems exist in Czechoslovakia, Poland, Romania, and the USSR.

The potential advantages of this type of system are obvious. There are built-in arrangements for the continuing review of professionsl attainment and competence so that ideally it should be possible to discover and develop the personal abilities of each individual, to point out and remedy weaknesses, and thus use the professional work force to the best advantage. It is also inherent in the system that access to continuing education is the right of every practitioner, so that the expenses of providing and attending courses are met by the state and, at least in theory, staffing levels provide for an individual's work to be covered while he is attending a course. In practice, there must be limits, in terms of both money and manpower, to what any nation can provide for this purpose, so that although some involvement in continuing education is compulsory for every professional, the time available for this participation may in fact be less than for the more favoured and better motivated professionals who operate under a voluntary system. There must be adequate opportunity for the evaluation of assessment procedures, for example for a comparative study of the opinions and conclusions of different general practitioner supervisors in comparable situations; for it is on the assumption

of some general uniformity of standards that such a system must ultimately rest. But studies of this kind would be difficult and expensive to arrange.

3.2. Other systems

In the eastern European system, the essential linkage between continuing education and career development lies in the absence of tenure in professional appointments, and in the concept of accountability at all levels. Both of these principles are entirely alien to the traditions of most western European countries, where it has long been held that a senior appointment, obtained after many years of training and experience, is a permanent and unassailable position, and where the independence of the individual practitioner and his absolute right to determine his own methods of patient care are sacrosanct. Yet what applies to many non-socialist countries does not apply to all; traditions vary and changes of attitude occur more easily than is sometimes supposed.

In the United States and Canada, for example, it has often been the practice for appointments to the staff of a hospital to be reviewed annually, so that at least in principle the same opportunity exists for "relocation" of weaker members of the staff as in the eastern European countries. Autonomy, or autocracy, in clinical practice is at best a relative term; the freedom of the independent practitioner is always restricted in certain ways, for example with regard to the range of pharmaceuticals that may be prescribed, the equipment that may be purchased, the demands that may be made upon the local hospital, upon colleagues and other health professionals, and so forth. The use of promotion or demotion as a reward, or sanction, in relation to competence and continuing education, is thus not restricted to the socialist countries with fully integrated health care systems, and it will be referred to again.

In private practice, where each doctor lives and prospers according to his own efforts and the reputation that he is able to build, the concept of promotion, in the usual sense, is irrelevant. The same applies to private practice in other health professions, for example physiotherapy, chiropody or podiatry. Likewise in general practice, there is not usually an inherently hierarchical career structure, so that once a doctor has become an independent practitioner, or principal, there is often no question of further promotion and any quest for additional appointments will usually be in the academic or administrative spheres rather than in a purely clinical context. In the hospital-based specialties promotion is everywhere a powerful factor, because of the graduated career structures that exist.

Even more powerfully, in many countries, the hierarchy applies to academic appointments, and here there is real danger of confusion between clinical and teaching ability, academic attainment and administrative responsibility. To expect every holder of a senior university appointment in a

medical faculty to be equally competent in clinical practice, teaching, research and administration would clearly be absurd but there is no uniformity between countries, or often even within a country, concerning the criteria for promotion or even the meaning of "promotion". Continuing education, and indeed basic training, should of course be available, to graduates of all degrees of seniority, in teaching methods, research techniques and the principles of administration. More importantly, perhaps, the people concerned should avail themselves of such teaching, for here is an example of a situation in which "career development" often owes little or nothing to manifest ability or willingness to learn.

If continuing education is not a compulsory feature of practice in medicine and the other health professions, then there must be some motivation to engage in it. This does not imply the absence of motivation in a fully-integrated socialist system; it merely emphasizes the added importance of analysing motivation where compulsion does not exist.

4. INCENTIVES

4.1 Self-motivation

As already stated, the importance of encouraging and developing the right approach to professional practice and life-long learning, during the undergraduate period, cannot be overemphasized. In the United Kingdom, the Royal Commission on Medical Education (1968)[a] wrote: "compulsory continuing education would not in our view, create the receptive spirit which is necessary if training is to be effective, especially at later ages; more positive measures are needed to create a climate in which doctors have a desire for continuing education. Undergraduate education and postgraduate professional training arrangements have a big part to play in this: they should inculcate in the doctor a pride in the job for which he has been trained and a realization that advancing maturity in no way reduces the appropriateness and helpfulness of systematic learning. Without such attitudes the right climate for continuing education will not exist. Although monetary incentives may sometimes be helpful in encouraging continuing education, we think that the interest of doctors themselves in keeping up to date would usually be sufficient: on the other hand, no doctor should suffer financial loss in making reasonable efforts to do so".

[a] *Royal Commission on Medical Education, 1965–1968.* Report. London, HMSO (Cmnd 3569).

The emphasis here is on "pride in the job", which is as important for other health professionals as for doctors. The professional who makes an effort to keep himself up to date, and extend the scope of his knowledge, will enjoy heightened satisfaction in his work and enjoy the good opinion of colleagues, students and patients. The satisfaction and sense of self-fulfilment derived from this should be the most powerful of motives.

4.2 Contact with colleagues and students

"People who work in hospitals do have one enormous advantage over the labourers in the field. Hospital doctors work as part of a team, and they are kept up to scratch by constant contact with their fellows, the sharing of ideas and the knowledge that their performance is being watched by others competent to judge its worth. Family doctors lack these valuable stimuli, although a good group practice or a thriving health centre may provide some measure of that kind of intellectual nourishment. But it is true to say that, because of their circumstances, general practitioners are more in need of a structured programme of continuing education than their hospital colleagues."[a]

These remarks of a general practitioner emphasize the enormous importance of continuous contact with professional colleagues as a motive in continuing education. The equal importance of contact with students will be referred to later in this report. Professional isolation poses great problems, which are often increased by the fact that the single-handed practitioner faces an almost intolerable burden of routine work and feels a personal responsibility towards the community he serves which, while satisfying in itself, imposes great emotional and physical stresses. In the words of a professor of general practice:[b]

"There is a limit to what we can expect of any doctor who sees a hundred patients a day, or who works without help. Our expectations clearly ought to be less than those we have of the doctor who sees say 40 patients. What in fact doctors put upon themselves is one thing, what it is reasonable and ethical to put upon them as part of a contractual obligation is another".

Here there is the greatest need for continuing education and the greatest difficulty in finding the means and the motivation for it. Of course, it must be remembered that the latest medicine is not always the best; the greatest advances of today may be the biggest disappointments of tomorrow, so that less is lost than is sometimes supposed through a failure to keep absolutely up

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[a] **Gould, D.**, *Are we teaching the right topics to the right people? 1. The continuing education of doctors*, National Association of Clinical Tutors, 8th annual meeting, 1977. London, Update Publications, pp. 5–6, 1978.

[b] **Higgins, P.M.**, General practice: A nonacademic point of view. *Journal of the Royal Society of Medicine*, 71: 865–869 (1978).

to date. But the need for continuing education, and the opportunity to gain from it, is unquestionable. Wherever possible, professional isolation should be prevented, or limited in time, by the development of group practices, health teams, contact with hospitals, exchange appointments and other forms of increased job mobility. Those practitioners who remain in relative isolation, or prefer to work in this way, must be determined enough to maintain their competence, and here training, selection, and the monitoring of progress are all important if the community is to receive the quality of service it deserves.

4.3 Professional standing

Professional standing depends partly upon the opinion of colleagues and partly upon the overt recognition that is given in the form of promotion. Several problems arise in relation to the use of promotion as an incentive, or reward, for active involvement in continuing education. Firstly, as already mentioned, there are some forms of professional practice in which no hierarchy exists and in which promotion in terms of a higher position of authority, or a more senior title, is not practicable. Even where such a hierarchy does exist, it would be generally agreed that measured involvement in continuing education, in itself, should never be more than one factor to be taken into consideration.

Secondly, there is the question of precisely how continuing education can be invoked as an index of suitability for promotion. Mere attendance at a given number of meetings or the achievement of a given number of "credits" is almost meaningless. What is required is some form of assessment of the value gained from these attendances, together with an appreciation of the private efforts that individuals may have made. The quality of undergraduates cannot be measured by the number of lectures they attend, the number of books they buy, the number of questions they ask, or the number of hours they spend in the library or the hospital. The most brilliant students may be the most exasperatingly poor attenders; the dullest, the most dogged. The same applies to practising graduates, and the question is whether credit should be given for efforts or for achievement. Should doctors and other health professionals be promoted according to how hard they try to keep up to date and remain competent, or according to how well they succeed?

Thirdly, there is the still more important question of what we understand by promotion, or professional advancement. Traditionally, promotion and advancement are associated with belonging to a more prestigious specialty, such as surgery or internal medicine, moving to a larger city, a teaching institution or a university post. Yet all governments are aware that the needs of the community are not best served in this way. The most competent and self-reliant professionals are often needed in rural areas and in fields of medical practice that require development. A gradual change, from the traditional order to one in which the highest status and professional esteem were to be

attached to those who engage in this type of work, would greatly influence recruitment outside the main centres and improve the quality of health care as a whole. If continuing education is to be linked with promotion or professional advancement, then a great opportunity exists to bring about this type of change, through making sure that professional advancement is properly defined, and that rewards go to the people whose aim is in the direction of the greatest need. A further opportunity exists in the linkage, or exchange of appointments between urban and rural practice. The Working Group heard of examples of arrangements whereby, as a form of continuing education, doctors from smaller provincial hospitals or rural practice come into the major teaching centres for a time, while urban specialists go out in exchange. There was strong support from the Working Group for such arrangements.

Fourthly, it should be re-emphasized that although promotion may be used as an incentive or reward, in some appropriate form, continuing education must not be regarded simply as a means to this end. The "career-orientated" professional is the most likely to seek continuing education for perhaps the least worthy motives. Whatever arrangements are made, therefore, to achieve some linkage between continuing education and professional advancement, steps must be taken to ensure that this advancement does not become identified, as is conventionally the case, with inevitable movement to a different post. This is especially important in regard to rural practice, and appointments in smaller hospitals and currently less prestigious specialties.

4.4 Money

Increases in salary or other financial benefits are alternative or complementary incentives to promotion, and may have a powerful influence on the distribution of doctors and other health professionals. The Working Group received information about schemes, for example in Hungary and Turkey, whereby higher salaries were offered to those who worked in rural areas; perhaps the most striking example was the recent Turkish decision to triple the salaries of rural health professionals, so that they are now paid twice as much as their counterparts working in the main cities. The difficult question, once again, is how such financial benefits should be related to continuing education.

There is clearly no shortage of ways in which this *can* be done. For instance, a minimum level of attendance at organized continuing education activities may be required to qualify for, and maintain, certain salary levels or supplementary benefits. This system was introduced for general practitioners in the United Kingdom in the 1960s and, in spite of much cynicism as to motivation, the general impression was that it did much good. Interestingly, some of the linkage has now been abandoned so that the salaries of senior general practitioners are no longer dependent on attendance; it is too early to assess the results of this change, but the hope is that once

participation has become the recognized pattern of life among younger practitioners, the habit will persist. In a health system in which payment is on a fee-for-service basis, it would be possible to relate fee schedules to participation in continuing education. If a specialist who could not produce evidence of having attended a certain number of continuing education sessions in each year could only charge a lower fee for his services, this would certainly encourage participation. But the same fundamental problem remains: that of knowing whether there is any justification, other than a purely empirical one, for making such a distinction. It is true that in a purely private practice system most doctors find it much to their advantage to keep up to date, especially in relation to pharmaceuticals, but it is also true that success in private practice does not necessarily denote the highest possible standard of professional competence.

The general conclusion must be that until a clearer relationship can be established between measurable participation in continuing education, and measurable improvement in professional competence, this participation can, at best, be only one factor in the adjustment of financial rewards. An instance might be the British system of distinction awards, which are increments to the salary of specialists allocated at the discretion of a national committee which receives recommendations from each region of the country. The awards are intended to provide some recognition of specially meritorious service; paramount importance is given to clinical ability and achievement, but research, teaching and administrative responsibilities are taken into account. Many factors thus operate, and the extent to which a candidate has kept up to date and developed his competence is clearly very important. Colleagues usually know how active a candidate is in attending meetings, courses and other educational programmes, and how assiduously he reads the literature; these factors are not measured in themselves, but the system may be regarded as an attempt to assess the effects of continuing education rather than to measure the amount of participation.

5. DISINCENTIVES

There are ways in which negative relationships can arise between career development and continuing education, so that it is necessary to consider not only incentives, but possible disincentives.

5.1 Loss of earnings

An important factor in some circumstances is loss of earnings as a result of absence from work. This may apply not only in private practice but in

some forms of organized hospital service. In some countries such as Ireland, specialists have often been remunerated strictly according to the number of sessions of work undertaken; if a session is missed, no payment is made. Such an arrangement makes no provision for annual or study leave, each of which must be taken at the specialist's own expense. More educationally enlightened systems of employment have made financial provision for study leave for a great many years. In all socialist countries and, for example, at the Mayo Clinic or the Kaiser Permanente in the USA, staff members have for long been expected to attend relevant conferences and meetings at the clinic's expense.

Each form of continuing education has its own merits, and locally organized activities can never be a complete substitute for an exchange of professional ideas at national and international levels. Nevertheless, the problem of loss of earnings serves to emphasize the need to provide a variety of activities, including short programmes extending over one or two days, or held during a weekend, and educational material which can be brought to the professional at his place of work.

5.2 Manpower problems

Unless adequate staff provision is made, there may be reluctance to attend meetings because of awareness of the additional burden that will be placed upon colleagues. Likewise, other members of the team may come to resent a colleague who spends too much time attending courses or meetings, and this may have a disturbing effect on the potential development of special skills.

In some cases, and perhaps particularly in the case of nurses, recruitment difficulties and an increasing workload may make adequate provision for study time almost impossible. This is a matter of great importance, which fundamentally affects the terms and conditions of service of professional staff.

5.3 Cost of continuing education

Related to the above problems is the question of overall cost. It has been estimated that the cost of continuing education is equal to the combined costs of undergraduate and postgraduate training. The actual sums of money involved are therefore very considerable.

However beneficent the parent organization may be, there must sooner or later be some limit to the number of expensive conferences and courses that can be sponsored for each individual. Some arrangement must exist, as in the British National Health Service, whereby professionals applying for study leave give details of the course or meeting to be attended, and the expected benefits; applications are then assessed by local study leave committees or regional overseas study leave committees.

It is a general principle, which the Working Group reaffirmed, that the expenses of a legitimate amount of participation in continuing education

should be met in such a way that the participant is not personally out of pocket. Numerous arrangements of this kind already exist, not only in the eastern European socialist countries, but in many other European countries. However, the arrangements are not uniform, and many of the other health professions are less well provided for than the medical profession. There is evidence, as mentioned in the Introduction, that in some cases trade unions are beginning to exert pressure on behalf of their members, to ensure that continuing education is recognized as an integral part of the job, and that appropriate arrangements are made for day-release or longer periods of study leave, with reimbursement of expenses.

5.4 Disillusionment

If continuing education programmes are poorly organized and disappointing, there can easily be disillusionment leading to apathy and disinclination towards future participation. There are a number of possible reasons for such disappointment, and great attention should be paid to the subject matter and content of the programme, the quality of the speakers, the standard of slides and other audio-visual aids, the relevance of the topics, the timing and organization of the programme, the suitability of the lecture theatres or other rooms that are used, the provision of adequate time for discussion and elucidation of difficulties, and the quality of catering and accommodation. There may be disillusionment because of a false impression of the purpose of the educational activity; those who expect instant results in terms of promotion or financial gain are likely to be disappointed, and rightly so. Once again, the real aims of continuing education must be clearly understood.

Lack of relevance is an obvious cause of disillusionment, and some of the narrow-mindedness of what is conventionally offered as continuing education can again be illustrated by quoting the comments of a general practitioner:[a]

"To be an effective counsellor and a good physician the general practitioner needs to know about the way in which sex can worry people, what it is like to live on supplementary benefits, the kind of help available to unmarried mothers, the nature of a day's work on an assembly line. The general practitioner needs to know how to handle grief and bereavement, and what life is like for a black teenager on the dole. He is not going to be able to give his patients the best possible service if his records and correspondence are chaotic, and if he is in constant trouble with his bank manager and the accounts.

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[a] Gould, D. *Are we teaching the right topics to the right people? 1. The continuing education of doctors*, National Association of Clinical Tutors, 8th annual meeting, 1977. London, Update publications, 1978, pp. 5–6.

"Perhaps family doctors are likely to be among the best educators of family doctors, but the list of experts taking part in the programme of continuing learning should also include (apart from various consultants) district nurses, policemen, bank managers, ambulance men, parsons, community physicians, community health council activists, industrial welfare officers, politicians, school teachers, pharmacists (most important), and anybody else who could help a general practitioner sort out both his patients and himself."

Here, surely, is an example of the true meaning of career development, in relation to a particular field of medical practice, and of a great, untapped potential for continuing education in promoting it.

There is little to be gained by expecting, or demanding, that highly skilled professional graduates should attend programmes of low quality and little relevance. On the other hand, there is plenty of evidence that, even on a purely voluntary basis, there will be enormous enthusiasm for first-class courses, scientific meetings and symposia which genuinely have something to offer. Arrangements should also be made to provide practical instruction, so that professional workers can be attached, in small groups or on an individual basis, to nationally recognized experts in a particular field of work.

A great advantage of voluntary systems of continuing education, without particular rewards or sanctions, is that the level of attendance, and the comments received, provide a measure of the quality of what is offered. It is certainly important that where continuing education is a compulsory feature of employment there should be some element of choice in regard to which courses and meetings are attended. Although there is the potential danger of duplication of effort, the healthiest systems are those in which more than one programme is available on each subject.

5.5 Inconvenience of attendance

It should not be forgotten that although adequate study leave and financial reimbursement may be provided, there is often still an element of inconvenience in leaving home to attend a course. This will be particularly true in the case of married women professionals with children. This problem is likely to increase, and appropriate arrangements have to be made since the need for continuing education is no less among those who have such difficulties. Much can be achieved by bringing continuing education into the home, in various ways, but it must still be made clear that this can never be entirely sufficient. Even if on a limited scale, some time spent away from the place of work, to meet and visit other colleagues and hear international authorities, is essential.

5.6 Career anxiety

Regrettably, there may in some circumstances be reluctance to become involved in continuing education because of fears about where it may lead.

This is related to the questions, already discussed, of relevance and the meaning of promotion. In some of the health professions, for example nursing, most qualified practitioners enjoy the work they do and obtain much personal satisfaction from direct contact with patients. Yet the career structure of the profession has developed in such a way that in order to achieve promotion it is necessary to leave the bedside and become involved in administrative and other duties. If the type of course that is offered under the guise of continuing education is perceived as a preparation for this kind of move, it will often be viewed with suspicion. Unfortunately, those who organize advanced courses, and see themselves as educators, assume that what is required is something that will lead to such promotion. Appropriate courses are needed for those few professionals who wish to become administrators, but as a general philosophy of continuing education any such movement is entirely misconceived. The fault lies with the career structure; the need is to provide adequate career incentives at the bedside, and continuing education which is relevant to the main stream of the work of the profession.

5.7 Lack of evaluation

Enough has already been said, in general terms, about the problems of evaluation in relation to continuing education. Disillusionment is inevitable if the feeling exists that those who train and teach are interested only in their concept of what is important, and are not conversant with the realities of professional practice. Two members of the Working Group suggested that it would be valuable to devise a means whereby those in practice could help to inform the teachers, while at the same time learning themselves. For example, all members of a specialty or profession might be invited at four- or five-year intervals to complete some form of examination on a voluntary basis, without fear of sanction or promise of specific reward. For those who elected to participate, model answers could be supplied which would have educational value. Respondents could be asked not merely to answer the questions sent to them, but also to comment on their relevance, on whether they would consider it worthwhile troubling to look up the answer, and on important aspects of practice about which questions had not been posed. In this way much might be learned about ways in which training programmes could be improved, and how specialist examinations, where they exist, should be modified.

6. SANCTIONS

Apart from the possible offer of advantages to those who participate in continuing education, there is the alternative philosophy of applying sanctions

to those who do not. This subject has been extensively discussed in recent years, particularly in North America. In practice, there are a number of mechanisms which could be invoked in order to ensure that the non-participant in continuing education found himself at a disadvantage. The practicability of these will depend on the professional and political organization of the country, and attitudes to them will vary with the degree of belief in the necessity of continuing education for all. Once again it must be said that in this context continuing education is all too often taken to mean merely those forms of organized activity at which some kind of attendance record can be kept. It has repeatedly been emphasized in this report that continuing education also takes place in many other ways which cannot readily be measured. For any individual, or at least for the majority, there may be a close correlation between the extent of overt participation and the time spent in private study, but this has yet to be proved. It is likely that for some practitioners, non-measurable forms of learning are of the greatest importance, so that extreme care is needed in applying sanctions which take no account of these.

6.1 Withdrawal of status

A modern interpretation of the traditional view was given by the Alment Committee on Competence to Practise,[a] in the United Kingdom: "the significance of these views on basic medical education is that, if the objective of medical education is to teach the sciences basic to medicine, together with a comprehensive understanding of clinical method and the development of clinical judgement which is fundamental to it, then recognition of a doctor's competence to practise medicine after he has completed such education satisfactorily should be a once-for-all matter, lost only through deterioration of mind or body by age or illness".

This clearly relates to basic medical education, and the extent to which the same considerations apply to continuing competence in a highly specialized capacity is debatable. Hence, particularly in North America, there have been moves towards relicensure of specialists at intervals, with the potential threat that specialist status might be removed. The current situation in North America was reviewed by Simpson, whose analysis is given in the Introduction to this report.

Participation in continuing education may clearly be used as a requirement for relicensure and, in the absence of any better criterion, some record of attendance is commonly demanded. This is by no means the only possible criterion for relicensure or assessment of continuing competence; a detailed discussion of the work of professional standards review organizations would

[a] **Alment, E.A.J.** *Competence to practise.* The report of a committee of enquiry set up for the medical profession in the United Kingdom. Committee of Enquiry into Competence to Practise, 27 Sussex Place, Regents Park, London, 1976.

be irrelevant to the main theme of this report, but it should be noted that this form of review is operative in some European countries, for example Poland, and may lead to loss of specialist status. A simple, continuing education requirement such as hours of attendance is less Draconian, more easily met, and less expensive to set up than alternatives such as professional standards review organizations. Its relative acceptability may commend it as being preferable to nothing at all, but should not obscure its limitations.

The ideal basis on which a relicensure requirement should be founded has yet to be evolved. Continuous refreshment and extension of knowledge would be necessary to survive such an ideal assessment, so that continuing education would, in effect, be measured by its results. As an alternative approach, the hope of those who require participation in continuing education from all professionals is that this will make relicensure unnecessary.

6.2 Restriction of privileges

It is commonly open to individual specialist associations, or institutions such as hospitals, to determine their own requirements for membership or appointment to the staff. It is thus possible to make stipulations concerning continuing education; those who failed to show evidence of participation might, for example, be denied hospital privileges or removed from the staff. This might in some cases have serious financial implications, and loss of membership of a professional association or academic body such as a royal college might imply loss of certain valuable privileges as well as lowered prestige.

In some respects this is a variation of the relicensure theme, although there would be considerable possibilities for wider experimentation with criteria and methods of evaluation.

6.3 Medical insurance

Where doctors and other health professionals pay malpractice insurance premiums these may be adjusted according to circumstances. This is not invariably the case; in the United Kingdom, at present, all doctors pay the same premium regardless of their specialty. But in many countries, and particularly the United States, premiums vary widely according to the type of practice and the consequent risks and costs of litigation.

It is a reasonable assumption, although probably not a proven fact, that some relationship exists between professional competence and the probability of malpractice litigation. If there were also to be a relationship between participation in continuing education and professional competence, then it would be reasonable, on an actuarial basis, for professional insurance premiums to be weighted according to this participation. The analogy would be with life insurance, with failure to participate in continuing education being

one of the "risks" contributing to the total premium. Since this factor would be entirely within the doctor's control then, if the differences in premium were substantial, there would be a strong incentive to participate.

A much more interesting aspect of the situation, however, is that if the insurance companies chose to operate in this way they would themselves have a powerful motive for evaluating the effectiveness of continuing education: in other words, they would wish to know, for their own purposes, how much failure to participate in overt continuing education actually added to the risk of litigation. This, in turn, might give valuable indirect information about the relationship, if any, between overt continuing education and professional competence.

6.4 Loss of teacher status

To an increasing extent, in many countries, education of health personnel takes place beyond the confines of the university hospital. This trend is particularly evident in medical education. Increases in the number of medical students have made necessary the use of larger numbers of clinicians as teachers, at both undergraduate and postgraduate stages. Also, the introduction of postgraduate training schemes for general practice has necessitated the identification of both suitable teaching environments and practitioners worthy to be designated as trainers. In some countries, such as the United Kingdom, postgraduate training of specialists, and of future general practitioners, takes place in almost all hospitals; these hospitals are regularly visited and reviewed by senior representatives of the appropriate royal colleges and faculties. Similar arrangements exist, or are being developed, in many other countries.

In assessing the suitability of a hospital and its staff for training, great emphasis should be laid on the willingness of the staff to teach and their enthusiasm for keeping their own knowledge up to date. They will frequently be asked, during visits, about meetings, conferences and courses they have attended, and the junior doctors in training should be interviewed individually to obtain their opinions on the quality of the teaching and supervision they receive. Continuing education therefore becomes an important factor in continuing recognition for training. In the case of hospitals and general practices that are used for undergraduate teaching, comparable visits and assessments are made by the parent medical school.

The privilege of receiving undergraduates and junior doctors in training is highly valued. Loss of recognition for training, or the mere threat of its withdrawal, may well prove to be more powerful than any other conceivable sanction. There are also significant manpower implications, since loss of recognition for teaching and training, or even the acquisition of a poor reputation in this respect, may make it difficult to attract junior staff. This is certainly the case in the United Kingdom.

In nursing and several other health professions, training frequently takes place in a large number of institutions throughout the country. Indeed, very many hospitals are dependent upon their nurse training schools to provide such service, since student nurses constitute a major part of the available work force. Failure to meet the required standards, with consequent closure of the training school, would be a disaster leading almost inevitably to closure of the hospital. Here, therefore, is a most powerful sanction which can be linked with the benefits that are seen to come from continuing education, rather than with the counting up of hours spent in compulsory attendance at courses.

These are strong arguments for the wider diffusion of teaching, at both undergraduate and postgraduate levels. Students and trainees should have the opportunity of working in as many hospitals and general practices as can be encouraged to rise to the appropriate standard. This is of fundamental importance, because the mutual interaction between students and teachers is in itself probably the most effective method of continuing education. The presence of students and trainees, who bring with them new ideas, new knowledge, new questions and new criticisms inevitably provokes an improvement in local standards and makes it essential for those who become the local teachers to remain open-minded and up-to-date. The Working Group was strongly impressed by the importance of this trend in relation to continuing education and the career development that is inherent in the assumption of teaching status.

7. THE NEED FOR ACTION AND THE ACTION NEEDED

The public is entitled to have some assurance of the continuing competence of doctors and members of the other health professions. The days of professional autocracy and indifference to the concept of accountability are over. There is no doubt that the new state of affairs is wholesome, but it means that unless the medical and other health professions are seen to be taking adequate steps on their own behalf, it is likely that increasing pressure will be applied from outside. This would be undesirable, not only because of the resentment that it might engender, but because any form of attempted external control would inevitably lack the insight and understanding of the subtle difficulties of the exercise that the professionals themselves could bring to bear. In the United Kingdom, the Report of the Committee of Enquiry into the Regulation of the Medical Profession, the Merrison Report,[a] made this comment:

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[a] *Report of the Committee of Enquiry into the Regulation of the Medical Profession (the Merrison Report).* London, HMSO (Cmnd 6018).

"We take the view that the medical profession should be largely self-regulated. The principal reason for our view is that we have no doubt that the most effective safeguard of the public is the self-respect of the profession itself and we should do everything to foster this self-respect. The evidence put to us by the profession, through its various professional bodies, was devoted almost entirely to the question of how the profession might best serve the public interest, how it might be ensured that doctors of only the highest competence were put on the register, and how the professionally incompetent might most effectively and justly be removed from the register."

This, surely, is the philosophy that should control whatever steps are taken to ensure the maintenance of professional competence. It is of vital importance, therefore, that the medical and other health professions should make it absolutely clear that they welcome and wish to extend the principle of self-examination and assurance of competence.

The remaining question then is what part continuing education should play in this assurance of continuing competence. Taking the term "continuing education" in its most general meaning, its essentiality is unquestioned. In any of the health professions it is scarcely possible to imagine that competence to practise could continue in the absence of any kind of continuing education. However, any policy which sought to equate the measurement of attendance at certain forms of continuing education courses with continuing competence would be open to the most serious criticism. In the same way, there would be grave dangers in imposing sanctions for failure to comply with continuing education requirements, unless it could convincingly be shown that the activities on which the sanctions were based bore a meaningful and relevant relationship to the continuance and improvement of professional competence.

There is the complementary danger of imposing requirements which make insufficient allowance for the flexibility that should exist in a good professional system, and for the natural variation between individuals. Concerning relicensure, the Alment Report on Competence to Practise,[a] in the United Kingdom, elegantly expressed this concern:

"It is hence our view that there is as yet no evidence to justify re-licensure, not because there is no evidence that doctors fail in their competence in certain respects and that this can be detected, but rather because the system of licensing for all could not be based upon measurements satisfactory enough to justify it. Such a system would impose a demand for conformity in a situation in which the public is best served by diversity. It would replace trust in individuals by trust in system in a professional field where the trusted individual is the cornerstone of good practice. The public is better served by a

[a] **Alment, E.A.J.** *Competence to practise.* The report of a committee of enquiry set up for the medical profession in the United Kingdom. Committee of Enquiry into Competence to Practise, 27 Sussex Place, Regents Park, London, 1976.

profession exercising oversight over continuing education, expressing concern for the health and welfare of all doctors, and undertaking research into tests of the effectiveness of educational programmes."

It is this continuing research and enquiry, which must include a study of the uses and abuses of both sanctions and rewards, that is most badly needed.

Finally, it should be emphasized that whatever the political and administrative structure of a country may be, there must be effective machinery at central, regional and local levels to ensure that continuing education is available and of reasonably well-controlled quality, and that its relationship to competence and career development becomes better understood. The necessary administrative arrangements can be made in various ways, depending upon how the professions are nationally organized; the important point is that continuing education can no longer be left to chance, or to the uncontrolled activities of pharmaceutical companies and others.

8. RECOMMENDATIONS

In summarizing its discussions, which covered a very wide range, the Working Group made the following recommendations:

(1) Just as undergraduate and postgraduate training are controlled and administered by academic and other bodies at national, regional and local level, so should continuing education be controlled and organized by appropriate bodies.

(2) Continuing education is needed by all medical practitioners and other health professionals. Although participation may be a factor contributing towards promotion or professional advancement, it is not a means to this end, and advancement should not necessitate movement to a major city, a prestigious specialty, or away from the fundamental task of patient care.

(3) Continuing education should be an integral part of employment. Adequate provision should therefore be made for it as a matter of course, in terms of manpower, study leave and financial reimbursement.

(4) Since the mutual interaction between those who teach and those who learn is vital to the wellbeing of all who work in medicine and the health professions, both undergraduate and postgraduate training should take place in the widest possible range of hospitals, clinics and practices.

(5) An adequate proportion of the health budget should be set aside for continuing education, bearing in mind not only the cost of providing the various forms of activity that are required, but the need for sufficient staff to enable continuing education to take place.

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